(4) documentation of recommended referrals to health care providers; and

(5) other factual information relevant to the case, including but not limited to

- date of service
- name of child
- Medicaid I.D. number of the child
- name of person providing the service
- nature of the service
- place of the service

e. Track all EPSDT and other medical appointments. Follow-up on broken appointment within one week of the appointment;

f. Assist in making transportation arrangement for medical care--however the case manager will not personally be expected to transport the child;

g. Assess need for referrals to other providers such as social workers, home health care providers, nutritionists, psychiatrists, etc. as determined necessary by the medical care provider or the case manager.

E. Qualifications of Providers:

Provider Agency

To be recognized by the Missouri Department of Social Services, recognized Division of Medical Services as a case management provider agency, all the following qualification must be met:

1. Be enrolled as a Missouri Medicaid provider in Jackson County, Missouri;

2. Have at least two years experience in the delivery of public health or community health care services;

3. Have at least two years experience in the development and implementation of coordinated child health care plans;

4. Be able to demonstrate the ability to assure that every child being case managed has access to comprehensive health services; and

5. Employ, as case managers, registered nurses (RN) licensed by Missouri or physicians (M.D. or D.O.) licensed by Missouri.

6. Employ other needed office staff such as medical social workers (MSW) certified by the Academy of Certified Social Workers; licensed practical nurses (LPN); typists; and people capable of answering the phone, maintaining files, and preparing mailings.

7. Provide appropriate internal methods of resolving and recording grievances which will be written and submitted for review.

Individual Case Managers

Individual case managers must meet all the following criteria:

1. Education/Experience --

Be a Registered Nurse (RN) licensed by Missouri or a physician (M.D. or D.O) licensed by Missouri;

2. Have Knowledge of --

- Individual health care plan development and evaluation;
- Federal, state and local entitlement and categorical programs related to foster care children and Missouri Medicaid Program;
- The workings of the Missouri Division of Family Services;
- Community health care systems and resources;
- Child and adolescent health care standards, including EPSDT guidelines.

3. Have the Ability to --

- Coordinate and assist in the delivery of a plan of health care with all members of a health team;
- Interpret medical findings;
- Develop an individual medical care plan based on an assessment of client health, nutritional status and psycho/social status, and personal and community resources;

- Establish linkage among service providers;
- Coordinate multiple agency services to the benefit of the child; and
- Evaluate client progress in accessing appropriate medical care and other needed services.

F. Missouri assures that the provision of case management services will not restrict an individual's free choice of providers in violation of 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Missouri

CASE MANAGEMENT SERVICES

#19

A. Target Group:

All Medicaid eligible persons with a developmental disability, except those who reside in an Intermediate Care Facility for the Mentally Retarded (ICF-MR). A developmental disability is a disability which-

1. Is attributable to:
   a. Mental retardation, cerebral palsy, epilepsy, head injury or autism, or a learning disability related to a brain dysfunction; or
   b. Any other mental or physical impairment or combination of mental or physical impairments; and
2. Is manifested before the person attains age twenty-two; and
3. Is likely to continue indefinitely; and
4. Results in substantial limitations in two or more of the following areas of major life activities:
   a. Self care;
   b. Receptive and expressive language development and use;
   c. Learning;
   d. Self-direction;
   e. Capacity for independent living or economic self-sufficiency;
   f. Mobility; and
5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated.

B. Areas of the State in which services will be provided:

Entire State.

C. Comparability of Services:

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Casemanagement for developmentally disabled individuals.

Purpose Casemanagement is a system intended to assist eligible individuals in gaining access to needed medical, social, educational, and other services. In order to assist the individual client comprehensively, the responsibility for locating, coordinating, and monitoring those services which are needed by each client is placed with a designated person or organization.

Casemanagement activities include:

1. Assessment of the individual's need for medical, social, educational, habilitative and other services.

   a. Initially determining and documenting an applicant's need for individualized, specialized services for a developmental disability, including casemanagement. Also, informing and otherwise assisting the applicant or others responsible for the applicant during the assessment process.

   b. Obtaining necessary releases, collecting records, preparing ecological and behavioral assessments, arranging other assessments as needed, and coordinating the overall assessment process to identify the comprehensive array of services and supports needed.

   c. Facilitating individual habilitation plan (IHP) development and ongoing review as a member of the interdisciplinary team. Interpreting the comprehensive assessment and IHP outcomes to the client and/or responsible others.

2. Planning for services.

   a. From the IHP, developing and writing an individualized service plan which will enable the prioritized outcomes of the IHP to be attained.

   b. Periodically reviewing the individualized service plan to ensure it continues to be appropriate to the needs of the client and effective in achieving the prioritized outcomes of the IHP.

   c. When needed, as indicated by the client's response to the prioritized habilitation outcomes, redesigning the service plan to further promote individualized training and growth or to incorporate new outcomes.

3. Case Coordination

a. Locating appropriate service providers and community resources to provide the services specified by the service plan, and coordinating these services with other staff, collateral agencies and providers identified in the IHP.

b. Meeting with the client and his significant others (the client system) on an ongoing basis to plan, promote, assist and assure the implementation of the service plan and to guide and encourage their participation in strategies to address the prioritized outcomes identified in the IHP.

c. Directly assisting the client to access the services specified by the service plan, as well as any other services and resources needed to address the habilitation outcomes, including crisis services. Such assistance may include advocating on the client's behalf and escorting the client to services and resources when advocacy, escort or other guidance is necessary to assure the client's access to and utilization of those services and resources.

4. Case Monitoring.

a. Monitoring service delivery to assure implementation of the service plan and monitoring progress toward outcomes specified in the IHP.

b. Monitoring service delivery to assure the client is afforded both his legal and constitutional rights.

c. In response to negative monitoring findings, intervening with the planning system, client system, and/or service delivery system to address the problem(s).

5. Case Documentation

Completing necessary documentation on all aspects of casemanagement as it applies to individual clients, including case openings, assessments, plans, referrals, progress notes, contacts, due process requirements, discharge planning and case closure.

Time spent in casemanagement activities may consist of in-person or other contacts with the client and all others involved or concerned with his care, compiling and completing necessary planning and other documentation, and travel to and from contacts

and activities related specifically to the client. Service logs will be maintained which identify the recipient, the casemanager and the activity, as well as the date, units of service (5 minute increments), and place of service.

E. Qualifications of Providers:

Casemanagers will be employed by the eleven Regional Centers of the Missouri Division of Mental Retardation (Division of MRDD) or by County Senate Bill 40 Boards designated by the State. Casemanagement staff must meet either the minimum experience and training qualifications for a QMRP or, when employed by a Regional Center, they may be supervised by a QMRP and possess the alternative requirements specified in E.2. below.

1. The qualifications for a Qualified Mental Retardation Professional (QMRP) are the same as the minimum required for the position of Case Manager I with the Division of MRDD and require: One year of professional experience in social work, special education, psychology, counseling, vocational rehabilitation, nursing, physical therapy, occupational therapy, speech therapy, or closely related areas; and graduation from an accredited four year college or university with major specialization (24 semester hours) in the social or behavioral sciences, special education, nursing, adjunctive therapies, counseling, vocational rehabilitation or closely related areas.

2. As an alternative, casemanagement staff must possess a high school diplomma or GED, or have completed a training course for developmental assistant I approved by the Department of Mental Health, and in addition, have at least one year's experience in the care of a person or persons with developmental disabilities.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Missouri

II 19

CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children and youth 6 to 17 years of age who have a DSM III-R diagnosis, are Severely Emotionally Disturbed (SED) by the state's definition, require case management services, and are participating in, being discharged from, or are on a waiting list for community based, residential, and facility inpatient programs and services funded by the Department of Mental Health (DMH). Children receiving inpatient psychiatric care in a Medicaid certified institution will be eligible for case management services only within thirty days of their planned discharge.

The state's definition of SED is as follows:

1. Children and youth with severe emotional disturbance are those under 18 years of age who exhibit substantial impairments, due to the presence of a serious psychiatric disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R), in their ability to function at a developmentally appropriate level in two or more of the following areas:

a. Self care;
b. Social relationships, meaning the ability to establish or maintain satisfactory relationships with peers and adults;
c. Self-direction, including behavioral controls, decision making, judgment, and value systems;
d. Family life, meaning the capacity to live in a family or the equivalent of a family;
e. Learning ability; and
f. Receptive or expressive language;

2. The child's inability to function, as described, requires mental health intervention of at least 6 months to ameliorate the likelihood of substantial risk for decompensation;

3. The child is at risk of out-of-home placement because of his/her mental illness/disorder. Out-of-home placement can include detention, foster care, residential care (community placement) or inpatient; and

4. The child is in need of services from two or more community service agencies such as mental health, health, social services or juvenile justice.

B. Areas of the State in which services will be provided:

Entire State.

C. Comparability of Services:

Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. Definition of Services: Case management for children with severe emotional disturbance (SED).

Purpose: Case management will assist eligible children and their families gain access to needed psychiatric, medical, social, educational, vocational, and other services necessary to maximize the child's adjustment and functioning within the family and community. Case management will also serve to coordinate the multiple service systems which typically impact children with SED, thereby reducing stress and confusion for the child and his family and ensuring their receipt of comprehensive and quality care.

Case management activities include:

1. Assessment of the child's need for psychiatric treatment and rehabilitation, as well as for other medical, social, and educational services and supports.

   a. The case manager initially determines and documents an applicant's need for individualized mental health treatment and rehabilitation services. Also, he informs and otherwise assists the child's family or others responsible for the child or adolescent during the assessment process.

b. The case manager obtains necessary releases, collects records, and prepares or arranges for assessments to identify the comprehensive array of services and supports needed.

c. The case manager facilitates the assessment process and participates in the subsequent development of an individualized treatment plan (ITP) within his own (mental health) agency.

2. Planning for services.

a. The case manager initiates and coordinates the individualized service plan (ISP) planning process among all the agencies which will serve or otherwise be involved with the child. From the action steps of the individualized treatment plans (ITPs) of each of these agencies (e.g., school, court, family service agency, mental health agency), the case manager develops an ISP which coordinates each agency's activities and assures continuity of care.

b. The case manager participates in the interdisciplinary (mental health) team and in the interagency (community services) team to assure ongoing continuity and coordination of service delivery.

c. The case manager periodically reassesses the child's status, community functioning, strengths, preferences, needs, and progress toward defined outcomes, redesigning the service plan when needed.

3. Case Coordination

a. The case manager arranges the implementation of the ISP, linking children and families to services and resources and facilitating communication between caregivers.

b. For children who are planned to be discharged from a psychiatric hospital, the case manager helps implement the discharge plan. He meets with hospital staff and provides the link between the facilities' discharge planners and the community interagency and interdisciplinary